

FIG 1

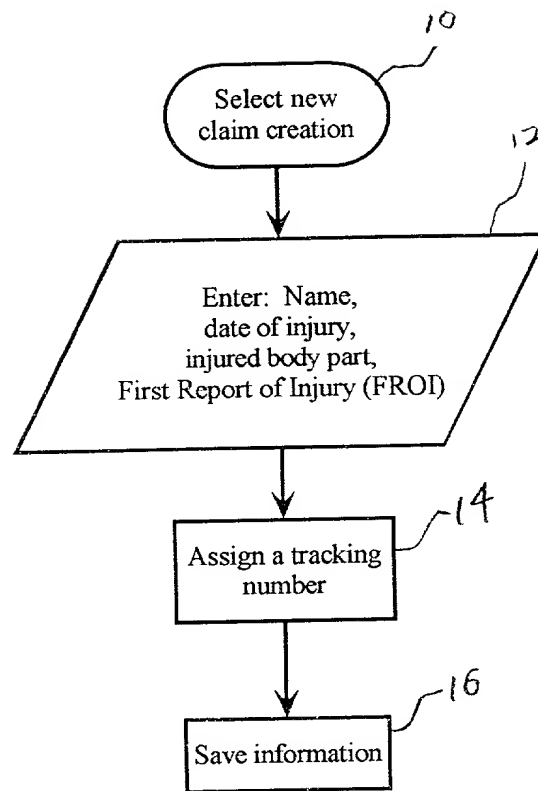


FIG 2

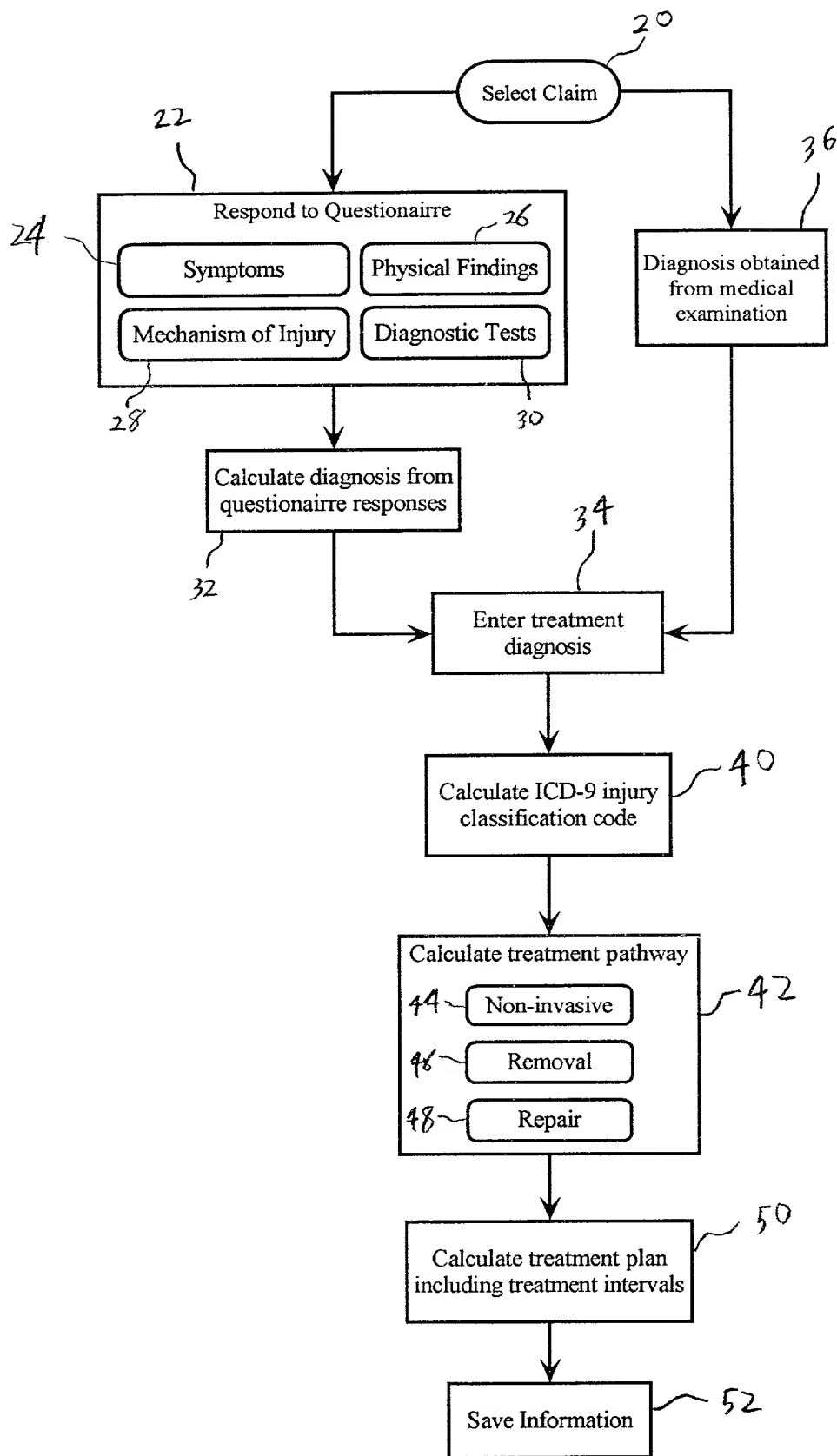


FIG 3

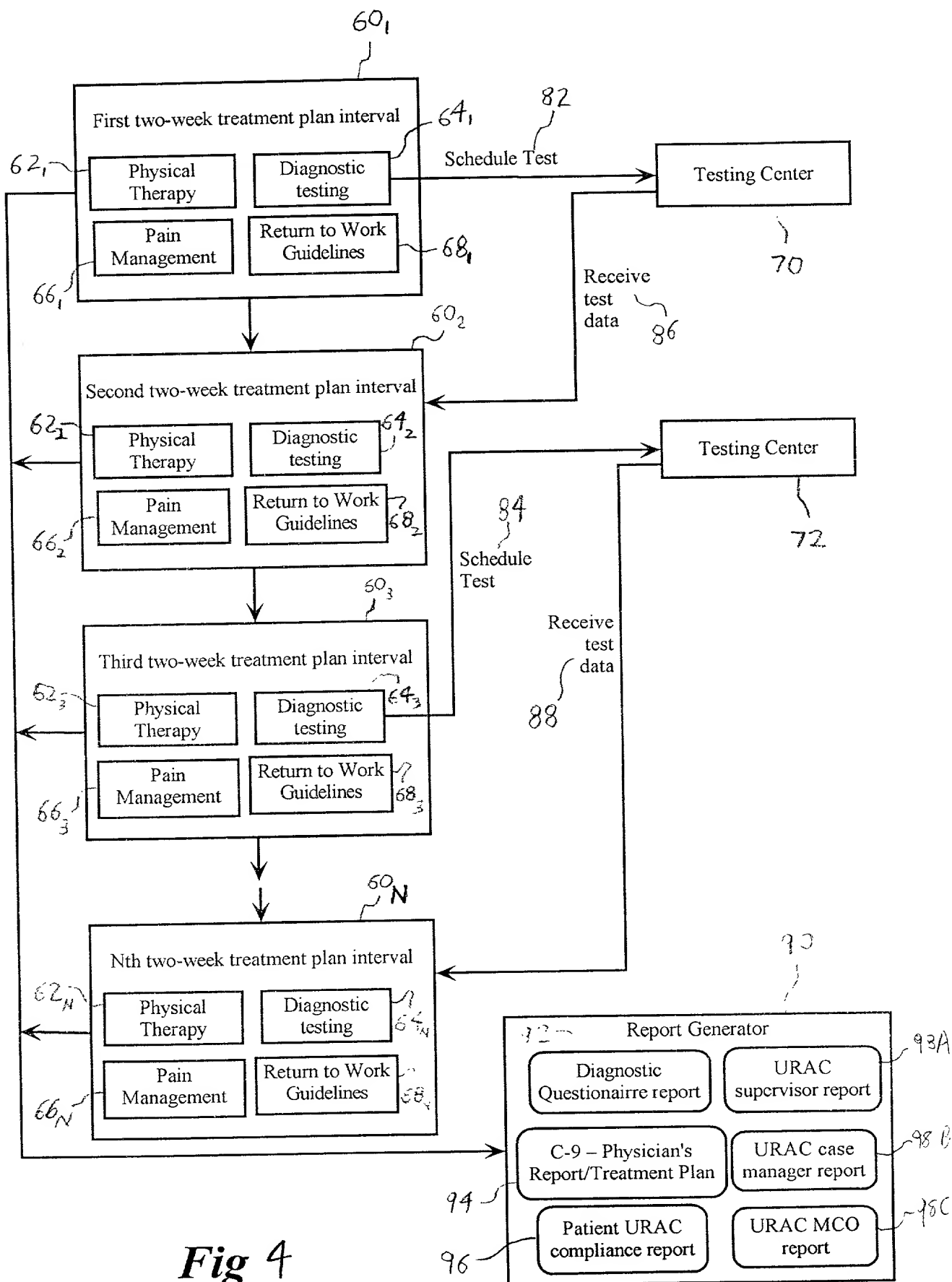


Fig 4

FIG. 5

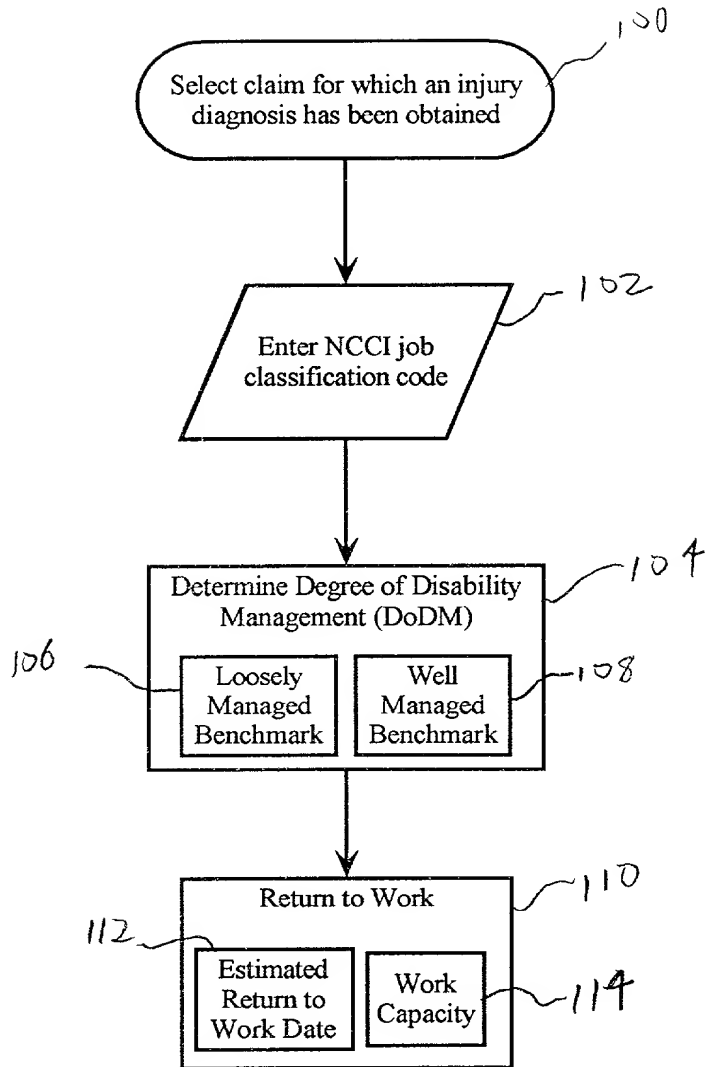


FIG 5

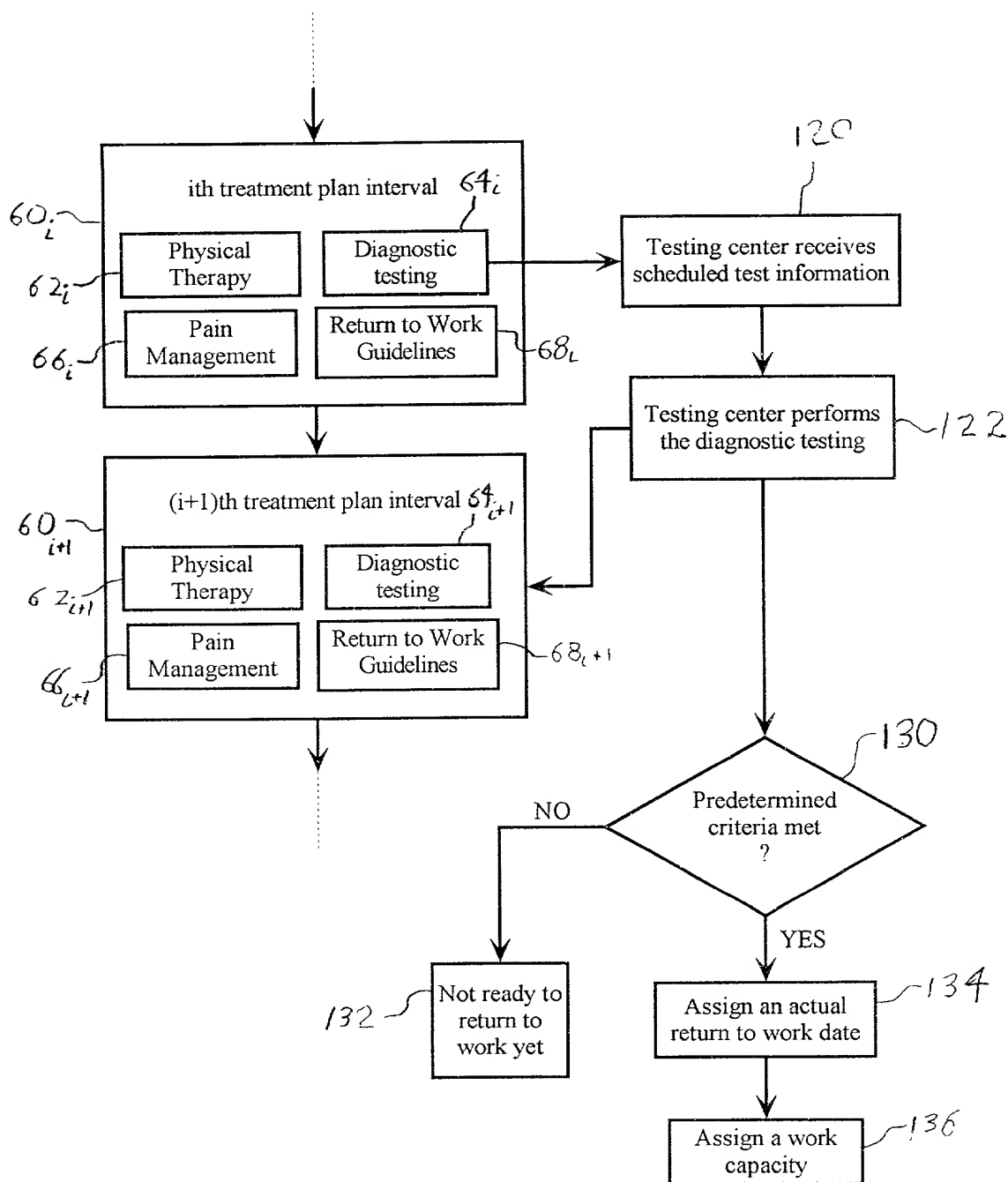
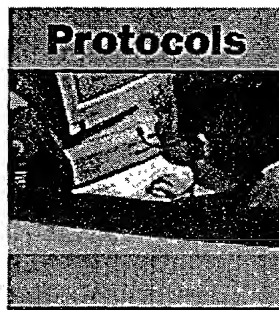


FIG 6



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"Manage disabilities, not resources".

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This is the suggested treatment plan for the selected diagnosis, treatment pathway effective dates. If there are no services suggested for this treatment plan, you will see **None** under suggested services. In addition, if you have not selected a treatment diagnosis, you will see **None** for suggested services and return-to-work guidelines

Claim Information

Name: Test Case2 **UPDATE**

Social Security #: 111-22-3333 **UPDATE**

Claim Number: **UPDATE**

Tracking number: 59BEXW33

Last Day Worked: 3/29/2001 **UPDATE**

Date of Initial Treatment: 3/30/2001 **UPDATE**

Effected body part: Shoulder

Diagnosis: Rotator Cuff Tear

ICD9: 840.4

NCCI code: None **Find DoDM**

DoDM:

Total Claim Days:

Physician of Record Code: **UPDATE**

Treatment pathway: Noninvasive

Treatment Intervals: 3/29/2001 to 4/11/2001

A

[<Create New Claim>](#)

[<Select An Activ](#)

400 — **Services**

600 — **Diagnostic**

800 — **Physical therapy**

Pain Management Utilization of appropriate anti-inflammatory medication, pain medication, and muscle relaxants to facilitate optimum rehabilitation and recovery.

Return to Work

Lower

Bending/Stooping/Crouching As Tolerated

Climbing Ladders No

Driving As Tolerated

Kneel/Squat As Tolerated

Lifting Floor To Waist 5 Pounds

Operating Heavy Equipment Not with Involved Extremity

Handwritten notes: X-Rays 3 Time(s) / week, schedule an X-Ray 402

Fig 7 (182)

800

Pulling/Pushing
Sitting
Standing
Twisting/Planting
Working on Scaffold

5 - 10 Pounds
As Tolerated
As Tolerated
No Restrictions
No

Upper

Climbing Ladders
Continuous/Repetitive
Gripping
Lifting at Waist Height
Operating Heavy Equipment
Overhead Activity/Lifting
Pulling/Pushing
Reaching

No
As Tolerated
As Tolerated
5 Pounds
Not with Involved Extremity
No
5 - 10 Pounds
Waist Height Only



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Fig 7 (2 of 2)

Protocols

"Manage disabilities, not resources".

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The Reports include suggested Therapy Guidelines for each treatment diagnosis, treatment pathway, or interval(effective dates).

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Claim Information

Arc

Name:

Test Case2

UPDATE

Social Security #:

111 22 3333

UPDATE

Claim Number:

UPDATE

Tracking number:

59BEXW33

Last Day Worked:

3 / 29 / 2001

UPDATE

Date of Initial Treatment:

3 / 30 / 2001

UPDATE

Effected body part:

Shoulder

Diagnosis:

Rotator Cuff Tear

ICD9:

840.4

NCCI code:

None

Find DoDM

DoDM:

Total Claim Days:

Physician of Record Code:

UPDATE

Treatment pathway:

Noninvasive

Treatment Intervals:

3/29/2001 to 4/11/2001

<Create New Claim>

<Select An Activity>

Therapy Guidelines

No immobilization

Exercise

Begin full ROM, active-assisted ROM, pulley and T-Bar

isometrics - submaximal

external/internal rotation

infraspinatus/teres minor

deltoid

must be pain-free, full ROM

scapula stabilizers

rhomboids

levator scapulae

trapezius

serratus wall push-ups

posterior capsule, anterior capsule mobilization

Modalities

Phono

Ultrasound

Cryo/ice

Fig 8 (1 of 2)

200 ~~~~~

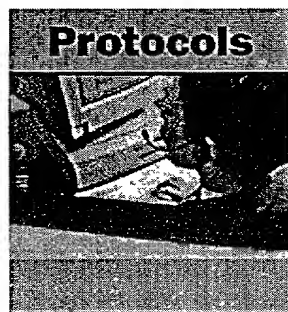
Ionto
EGS to posterior cuff
Aquatic Exercises
buoys for flotation - ROM
water walking - arms at side/palms forward
buoys with shoulders in 90 degree flexion/abduction
Manual Therapy
McConnell taping
frictional massage
Goals
decreased pain/swelling
increased ROM WNL
decreased painful arc
begin PRE
Patient Strength Education
lifting techniques
postural education

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Fig 8 (2 of 2)



Protocols

"Manage disabilities, not resources".

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PHYSICIAN'S REPORT/TREATMENT PL for Industrial Injury or Occupational Dise

INSTRUCTIONS

- Please print or type this report
- Be sure to enter four digits for the year in all date fields.
- Complete Part I and Part II of this form if this is the initial report/treatment plan, request for additional conditions or diagnosis has changed.
- If this is a subsequent treatment plan, or if extending dates of disability, complete Part II only.
- Attach additional notes if needed.
- Mail or fax to employer's MCO or self-insuring employer.

Part I

1. Injured worker name	Test Case2
Social Security number	111-22-3333
Claim number	
2. Employer name	
3a. Date of injury or diagnosis of disease	3/29/2001
3b. Date of first exam	
4. Describe the industrial injury or occupational disease	
5. Provide current diagnosis and ICD-9 code(s), location and site.	
1. Diagnosis	Rotator Cuff Tear
Code	840.4
Location	
Site	

00809425-070501

900

Fig 9 (1 of 5)

2. Diagnosis
Code
Location
Site

3. Diagnosis
Code
Location
Site

6. Complete if you are recommending additional condition(s) after the initial allowance the claim. Supporting medical documentation is required for all conditions listed

1. Diagnosis
Code
Location
Site

2. Diagnosis
Code
Location
Site

3. Diagnosis
Code
Location
Site

7. In your opinion is there a direct or proximate causal relationship between the diagnosis in 5 and/or 6 and the description of the industrial accident/exposure?

☐ Yes ☐ No Please Explain

8. Are there any pre-existing conditions, impairments, complicating factors or disease processes that have been aggravated as a result of the injury or that could impair recovery?

☐ Yes ☐ No...If yes, please describe

Fig 9 (2 of 5)

Part IIInjured worker name Social Security number Claim number 9a. Date of last exam or treatment 9b. Date of next appointment 9c. Date of return to work ☐ Actual ☐ Released ☐ Estimated

9d. Current period of disability due to the work-related injury/disease

From To

10. Has the work-related injury(s) or occupational disease reached a treatment plan at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)

☐ Yes ☐ NoIf yes, give date If no, please explain

11a. What was the injured worker's position of employment at the time of the injury/disease?

11b. Is injured worker medically able to return to this position of employment?

☐ Yes ☐ No If no, please explain

11c. Is injured worker able to return to other employment?

☐ light duty ☐ alternative work ☐ modified work ☐ transitional work?
Please list any restrictions that may apply.

12. Is vocational rehabilitation needed to assist with return to original job or different job?

☐ ☐

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Fig 9 (3 of 5)

Yes No If yes, please explain in the treatment plan below.

13. Treatment plan:

☐ Treating diagnosis ICD Code(s)

840.4

☐ Initial date☐ Subsequent date

Provide copies of current medical reports, and include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, etc.

1. Specific Type of Treatment: X-Rays

Meds:

Frequency: 1 Time

Duration: 2 weeks

Location:

Site:

2. Specific Type of Treatment: Physical Therapy

Meds:

Frequency: 3 Time(s) / week

Duration: 2 weeks

Location:

Site:

14. The following clinical findings are the basis for my recommendations: (Attach additional sheet if necessary)

Objective:

Subjective:

Physician basic & provider number mandato

CHECK ☐ if Physician of Record

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payments to which that person is not entitled, is subject to felony criminal prosecution and may be punished by a fine, imprisonment both.

Physicians Name:

Telephone Number:

Fax Number:

Physicians
Address:

City:	
State:	
Zip:	
BWC Provider Number:	
Date:	3/30/2001

☐ Check the box if you want to attach Diagnostic Questionnaire.



Print Format

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900

Fig 9 (5 of 5)

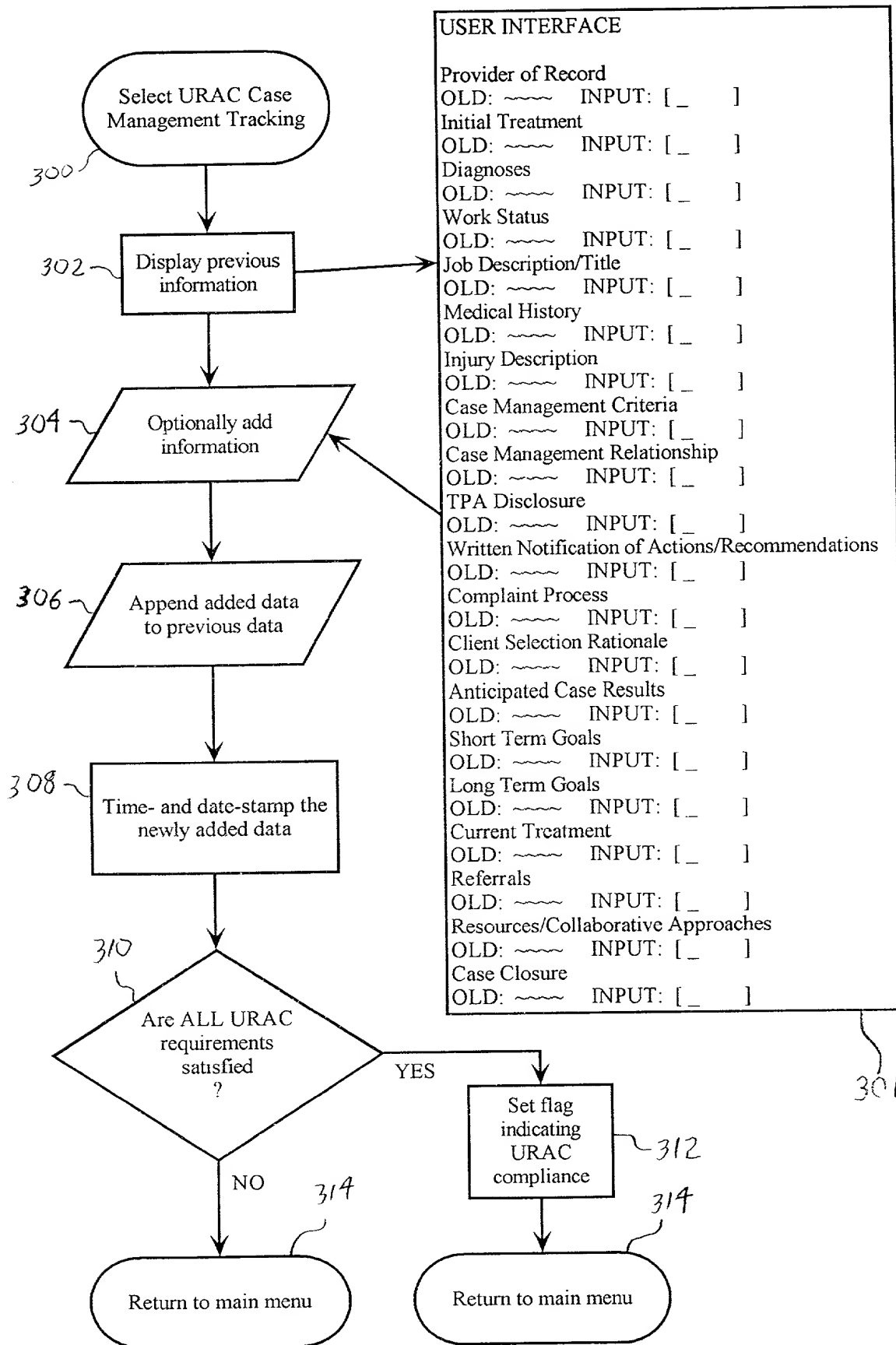


FIG 10